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Special Litigation Section - PHB
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Re: Mobile County Jail

Dear Counsel:

We write to provide you and your clients with the Department of Justice, Civil Rights Division's ("Department") assessment of current conditions at the Mobile County Jail ("Jail"). We are pleased to advise you that the County continues to make improvements with medical and several areas of mental health care. If, as detailed below, the County also makes improvements to classification and housing policies, prisoner supervision, use of force reviews, chronic care, and mental health care, we may be able to resolve this matter.

As background, on January 15, 2009, the Department formally notified Mobile County ("County") officials that it had reasonable cause to believe that conditions at the Jail violate the Eighth and Fourteenth Amendments of the U.S. Constitution. Jail deficiencies included inadequate prisoner medical and mental health care, the inappropriate use of restraints, excessive use of force, the failure to protect prisoners from harm due to prisoner violence, and unsafe living conditions. Since that time, the Department and the County have engaged in a voluntary remediation process designed to resolve this matter without litigation. This process included periodic evaluations of the County's remedial measures, ongoing provision of technical assistance through draft policy reviews, on-site discussions, written communications, and post-tour exit interviews.

On March 16, 2017, we issued a compliance letter that summarized improvements, ongoing deficiencies, and recommended remedial measures. Major concerns included inadequate supervision, inadequate use of force investigations, inadequate nursing and physician

oversight, inadequate internal quality improvement mechanisms, an overcrowded and unsafe physical plant, discrimination against female prisoners in the provision of programs and services, and inadequate programs for youthful offenders. Our letter also provided several measurable, priority remedial measures intended to resolve the issues we observed.

The Department recently re-inspected the Jail to assess current conditions and the status of County remedial efforts. From January 16-19, 2018, Department consultants and staff inspected the Jail. The consultants included experts in corrections and mental health care. The Department's general medical consultant was unable to join us as originally planned due to a family emergency, so we rescheduled his site visit for March 22-23, 2018. We appreciate the County and its contract health care providers' assistance in facilitating the additional inspection. During the visits, we reviewed documents, inspected the facility, and conducted both staff and prisoner interviews. Jail staff provided our consultants with access to the facility, staff, prisoners, and documents.

Please again extend our appreciation to your clients and Jail staff, including the contract medical personnel, for their cooperation.

As detailed below, the Sheriff's Department has made improvements in many areas, especially in regards to general medical care. This letter identifies our remaining concerns and includes recommendations, which if adopted, will remedy the most significant remaining deficiencies and should allow us to close out this investigation.

CURRENT CONDITIONS

A. Prisoner Supervision and Staff Oversight

The Jail needs to improve prisoner supervision and staff oversight, as deficiencies continue to expose prisoners to harm and impact other Jail operations. Prisoner management continues to be a challenge for Jail staff due to limited housing, continued population pressures, the lack of sound classification procedures, limited staff presence in housing units, and the lack of a prisoner behavior management program.[1]

The most significant deficiency is the lack of a sound classification and housing assignment system. Such a system could help alleviate a host of problems, such as poor use of limited housing, improper use of force, and prisoner-on-prisoner violence. Presently, the Jail uses a mostly charge-based housing assignment system and has limited housing options for separating different types of prisoners. For instance, it cannot separate high security from low security federal prisoners, alleviate crowding in female units, provide juveniles with sight and

[1] We continue to recommend that the County give as much attention to better utilization of existing space and Jail resources, as it has to other measures, such as jail expansion planning. In our last letter, we advised the County not to proceed with a building expansion until after it completed a formal needs assessment and explored alternatives, such as improved community mental health and diversion programs. While it did do some planning, the County did not conduct a comprehensive assessment, and it appears decisions were made without much input from the Jail administration.

sound separated housing space, provide programming space, separate prisoners from their enemies, and create space for a dedicated mental health treatment unit. A classification system would help the Jail staff separate and better protect high risk, low risk, and special needs prisoners. It would also help inform any ongoing County discussions about whether the Jail needs an expansion.

Without sound classification and unit supervision practices, the Jail staff must continue to use force. In Mobile, there is little internal oversight of such use of force. The Jail still does not routinely videotape planned uses of force, and post-incident investigations do not consistently include all necessary documentation (e.g. witness interviews, obtaining internal reports, and downloading videos). Some Jail managers have started videotaping planned uses of force, but the process is rudimentary and prone to error. The managers record events on their cellphones, but there are no policies or practices to demonstrate chain of custody or to handle routine storage and review of the videos. Jail managers indicated that there are plans to develop appropriate policies and adopt a video-recording program, but no such policies were in place during our tour. Indeed, Jail policies do not actually require a complete use of force review by command staff or an internal affairs referral, when an incident is serious enough to normally warrant such review.

Similarly, there are few safeguards on the use of restraints. The Jail now has a restraint chair, which is not covered by any policy. The Jail staff used the chair about 32 times from July through December 2017. In seven cases, staff placed a prisoner in the chair for between 1.5 hours and more than 7.5 hours. Despite the long duration of restraint, staff did not document medical, hydration, or restraint checks in six of those cases. For another 5 cases, staff did not produce the "inmate restraint forms" that are supposed to document such checks. Poor restraint record-keeping may reflect the broader problems with the way staff track and report serious incidents. Jail managers need to make sure officers are filling out reports and notifying appropriate personnel when serious incidents occur. We found cases where staff placed prisoners in restraints, but no corresponding notes were made in the individuals' electronic medical records. Similarly, we found mortality reviews that omitted mention of records showing mental health histories that should have been considered during the reviews. We found a 62-year old female prisoner with a known psychiatric history who was not receiving any psychiatric medications, and may have been restrained for unusual behavior without a record of the restraint.

Our security consultant provided extensive technical assistance during this visit, and Jail supervisors appeared open to making these changes. Indeed, they were reportedly already making some policy changes even before we toured the facility. After our visit, the County reportedly took additional, concrete steps to remedy some of the above deficiencies. Most significantly, the County sought and obtained a technical assistance grant from the National Institute of Corrections. The grant will assist the County in developing an objective classification program, which in turn should help the County better utilize Jail space, protect prisoners from violence, and better conform staffing levels to the security levels of individual units.

For now, however, we cannot say that the County is in compliance with constitutional standards regarding prisoner safety and prevention of violence.[2] Full implementation of an improved classification, housing, and supervision plan will be a major step towards resolution of this area of concern.[3] We understand the Sheriff is also reviewing a number of revised security policies, including supervision and use of force policies. We strongly encourage the adoption of revised policies, especially in regards to developing a behavior management program, use of the restraint chair, video recording, and review of use of force or other serious incidents.

B. Medical Care

The County and its medical provider have continued to make progress in providing prisoners with necessary medical care. We found that the Jail has substantially implemented the majority of our recent recommendations, including (1) improved physician clinical care and administrative oversight, (2) improved quality assurance, (3) improved nursing care, (4) improved tracking of chronic care patients, and (5) improved record-keeping and incident response. We note that the Jail has a new physician, who was responsive to recommendations made during our medical consultant's site visit and was in the process of implementing improvements. As long as the Jail maintains past improvements and continues refining medical policies and practices, we believe most of our concerns about medical care will be resolved. The only major substantive deficiency remains in chronic care.

The Jail needs to continue improving the tracking and management of patients with chronic conditions, specifically those with diabetes, HIV, and mental illness. Currently, staff continue to hold appointments with chronic care patients without first obtaining necessary laboratory and test results.[4] Such test results help medical professionals determine whether a prisoner's condition is stable, whether the prisoner may be experiencing sometimes serious side effects from medications, whether poorly controlled conditions may be causing serious physical effects, and whether staff need to make changes to medications. The new Jail physician appears to appreciate the importance of this issue, and more generally, the medical provider has expressed a willingness to make additional changes needed to improve chronic care.

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[2] Despite some promising recent steps, we note that some of our recommendations are longstanding. For instance, we have long recommended a more structured classification system, eliminating the use of prisoner "buddies," better documented rounds, more intensive staff supervision (especially in administrative segregation and mental health units), and related changes to security policies and procedures.

[3] We understand that the County was not able to obtain NIC funding for the development of a prisoner behavior management program. A prisoner behavior management program is important because it will give the staff more tools for dealing with prisoner misbehavior, create a more well-ordered living environment, and reduce the need to use force. Our consultant, however, provided a number of recommendations that Jail staff should be able to use to develop a basic program. For instance, Jail staff need to exercise more oversight over the cleanliness of their housing units, by requiring prisoners to keep their cells clean and providing supplies regularly. The Jail can develop rewards and impose restrictions on those prisoners who do not comply with Jail rules. Implementing such a program will depend in part on whether the Jail has more housing flexibility, which in turn depends on development of a classification system and better management of population levels.

[4] The medical staff have made some improvements in getting such information for some conditions, and staff do sometimes do obtain lab work when instructed. But overall, this is a work in progress.

In the meanwhile, we continued to find cases of poorly monitored chronic illness. For instance, our expert found at least six HIV and diabetes patients who were seen in the clinic without test results to determine if their diseases were under control. He also found at least seven patients on psychotropic medications without any testing for metabolic syndrome (elevated blood sugar, diabetes, elevated cholesterol). Even if none of these individuals were immediately harmed by the gap in care, inadequate monitoring of chronic conditions poses a serious risk of harm to such patients. As discussed in more detail during an earlier compliance inspection, the Jail had a 2015 death related to uncontrolled diabetes. That prisoner was on an antipsychotic medication known to have diabetes as a potential side effect. The prisoner was not being monitored for the side effect while on the medication.

The County thus needs to improve scheduling and staff coordination so that tests are completed and available for review by the time of a prisoner's chronic care clinical appointment. Medical staff need to use the clinical appointments as a way to assess disease control and possible adverse consequences related to the chronic disease process. The staff should modify treatment plans as necessary to improve control of the disease symptoms and to stabilize or prevent the types of harmful consequences associated with poor control of chronic diseases.

The County should also consider giving the Jail physician more responsibility and authority for directly managing the care of patients with chronic conditions, particularly those with more complex diagnoses. As a separate but related issue, Jail policies may still give the nurses too much discretion on whether to notify the physician (or nurse practitioner) when a patient complains about symptoms. For instance, the Jail's nursing assessment tools require notifying a doctor if a prisoner has "severe abdominal pain." Such a vague standard could result in a nurse overlooking a serious situation. When evaluating how to tighten nurse-physician coordination, the County should therefore review the assessment tools, making them more specific in conformance with clinical standards.[5]

C. Mental Health Care

While we noted improvements across the facility, we remain concerned about Jail mental health services, particularly issues that are primarily within the purview of security or fall in the intersection between security and mental health staff duties. The five most recent deaths in the Jail involved prisoners with a mental health or substance abuse history.[6] In some of the mortality cases, prisoners mentioned a family history of suicide, feelings of depression, or engaged in self-injurious behaviors. So at some point, officers or other personnel recognized something

[5] At the time of our medical consultant's tour, the Jail had a vacant nurse practitioner position. It normally has a total of 80 nurse practitioner (NP) hours and 12 physician hours. Our consultant has previously expressed some concern about the heavy reliance on NP hours as a substitute for physician coverage. He has recommended more physician hours in the past. With the current medical director, the staffing balance between physician and nurse practitioner hours may be more workable, but only if the medical director continues to make himself available to staff even when he is not onsite.

[6] These deaths all occurred after 2015. As with incident reports and restraint logs, it is also important to continue improving records and internal quality assurance mechanisms to help prevent such events, or at least to learn from them after they occur.

might be happening. In one case, they even sent a prisoner to the hospital. Yet, it appears that important information never made it into the electronic medical records, which could then impact the quality of care and the thoroughness of mortality reviews. Also of concern, officers who responded to the incidents were not CPR-trained, and in one case, the officer's radio was not working. Regardless of whether staff could have prevented the deaths, these incidents do highlight shortcomings in the County's ability to self-identify and correct deficient practices or staff policy violations.

We acknowledge recent improvements. The new mental health director has made progress towards implementing Naphcare's policies, which has in turn improved mental health evaluations in the mental health units, communication between medical and mental health staff, patient records, and the Jail's relationship with community providers. A registered nurse completes all intake screens, which include questions about mental health, and prisoners receive psychotropic medications and re-evaluations in a timelier manner. A relatively new psychiatric nurse practitioner continues to improve treatment.

Security's ability to house, supervise, and respond to such prisoners remains, however, limited. The physical condition and cleanliness of cells, suicide smocks, mattresses, linens, and other conditions in mental health units are poor. As is true elsewhere in the facility, graffiti covers the walls, prisoners are sleeping on floors, and general living conditions are not therapeutic. Staff continue to rely on prisoner "buddies" to supervise suicidal prisoners, a practice that we have previously warned leads to dangerous situations. Staff rely too much on segregation cells for suicide/mental health watch, conduct assessments in areas that do not protect patient privacy, move prisoners to general population and medical housing before mental health evaluations have been completed, and do not fully utilize the booking/intake process to inform housing assignments and identify prisoners at risk of self-injury or other harm. The pill call process remains a problem area. Medical and security staff are supposed to work together to make sure prisoners are taking their medications, but we observed that actual practice does not comply with policies.

More generally, the security staff need a better understanding of when (and what) they need to communicate with medical and mental health staff, such as making sure everyone knows when a serious incident may indicate that a prisoner is talking about suicide, behaving erratically, causing discipline problems, or otherwise at risk of harm. Instead, the security staff continue to make housing, disciplinary segregation and restraint decisions, without adequate input from classification and medical staff.[7] None of these recommendations are new, but the County has not made as much progress in improving security practices as it has made on the medical provider side. Ironically, the County has actually *decreased* the number of hours of basic jail training on mental health issues.

The lack of a sound classification and housing system also limits mental health housing options. The Jail does not have a stepdown unit or the flexibility to find appropriate housing for

[7] The use of force, use of restraints, and serious incidents, are sentinel events which should trigger prompt review and often medical follow-up.

persons who have special needs.[8] But to develop such options, the Jail needs to find some space in existing facilities. Right now, the housing system is not well adapted to the Jail's needs. Placing prisoners who are suicidal in single cells under a buddy watch can put prisoners at serious risk of harm while also wasting limited housing resources.

RECOMMENDATIONS

The Jail continues to make improvements and is on its way to fully implementing many of the priority recommendations made in our March 2017 compliance letter. We now provide the following more specific action steps, which we hope will expedite implementation of the priority recommendations and resolution of this matter:

A. Prisoner Safety and Supervision.

- The County should proceed with its National Institute of Corrections (NIC) review of classification and housing policies.

- Based on the NIC classification review and recommendations, the County should then implement objective classification, housing assignment, and related security policies. As part of this process, we suggest the County work with a jail design specialist to identify the level of supervision needed in all of the special management units.

- The County should develop a behavioral management program. The County should obtain the additional technical assistance from NIC as soon as funding is available. Even without an NIC grant, the County can start the process based upon our expert's on-site technical assistance. For instance, the County should obtain training and technical assistance materials from NIC's library (www.nicic.gov) or from other professional associations. We can also discuss making DOJ's expert available for additional technical assistance.

- As part of the revamped classification and housing systems, County officials should continue to seek technical assistance about making efficient and more appropriate use of Jail space. For instance, the County should consider creating a designated intake/classification unit, which will be critical to ensuring that detainees are screened for classification and given a better orientation before being assigned to general housing.

- The County should not expand the Jail with a new structure or additional housing, until after (1) determining security staffing needs (based on sound classification

[8] Some of these deficiencies also have security implications. For instance, most new Jail detainees will be released within a short time of booking. It is unwise to move people quickly into general population, as doing so means exposing prisoners who have barely been screened to more seasoned prisoners. This has particular implications for special needs prisoners. Lack of outdoor exercise and denying prisoners access to dayrooms also create stressors and exacerbate prisoner management problems.

analysis) and (2) hiring the full staff contingent needed to operate a new unit.

- The County should also work to reduce lockdown time throughout the facility. Implementation of objective classification and prisoner behavior management should assist with this process.

- The County should develop video recording policies, which should include policies on the collection, storage, and use of such recordings. These policies should specifically address the review of such recordings as part of any incident review or investigation.

- The County should develop a restraint policy. The policy should define who may order the use of a restraint chair (or other security and medical restraints) and release from the restraint chair, limits on the duration of restraints, a schedule for welfare checks and bathroom breaks, a schedule for nursing and physician review, and documentation requirements.

B. Medical Care.

- The County should improve training and supervision to ensure that during medication rounds in the housing units, officers stand with the nurses throughout the process. Staff members should require every prisoner who receives medications to stand in front of the cart and swallow the medication. The prisoner's mouth should then be checked, and the prisoner required to speak before being allowed to turn and reenter the housing area.

- The County should prohibit staff from refusing to give medications to prisoners merely because someone else in their housing area is misbehaving. Even if a disruption temporarily prevents staff from completing medication rounds, the staff still need to make every effort to get medications to those who need them.

- The County should provide more privacy in the health screening intake areas.

- The County should continue to develop and refine quality improvement systems, scheduling practices, and lab testing policies to provide better management of prisoners with serious chronic conditions, including mental illness. For instance:

    i. The quality improvement program should include monthly monitoring of the chronic care program, focusing on the appropriateness of individual treatment, follow-up plans, and diagnostic blood work when clinically indicated.

    ii. The staff should develop an audit tool for the physician to review the health assessment charts that are signed by the nurse practitioners, and an audit tool that evaluates whether clinically necessary blood work is available for an appointment.

- The County needs to continue improving the mortality review process, with specific emphasis on the quality of reporting about patient histories, incident histories, and intake symptoms.

- The County should continue to improve physician care and staff oversight. For instance:

    i. The medical director should do the mortality reviews.

    ii. All registered nurses who are assigned to perform health assessments should participate in annual training directed by the physician.

    iii. The physician should improve oversight of the nurse practitioner by periodically reviewing health assessments when he does his monthly chart reviews, with particular emphasis on review of chronic care cases.

- The County should continue to refine nursing assessments to make them more specific, and thus limit the degree of nurse discretion when deciding whether to notify a physician about symptoms. For instance:

    i. The protocol for abdominal pain may need to require a physician referral if the patient meets certain other clinical criteria, such as fever, nausea and/or vomiting.

    ii. The County should ensure that the provider continues to develop clinical guidelines for patients on psychotropic medications.

C. Mental Health Care.

- The County needs to continue improving suicide/mental health watch policies and practices, specifically those involving security and nursing staff. The policies should include a step-down process for those released from suicide watch, which in turn should include a schedule for follow-up mental health assessments. Prisoners should not be moved from the intake area and placed into regular or special housing until their health/mental health screening is completed. Such transfers to the suicide watch units might be acceptable, but only if the Jail provides continuous direct supervision for those units.

- The County needs to replace the "buddy" system with a staff-based, "direct supervision" system of watches and welfare checks for suicidal prisoners. Even if the County must use "buddies" in the interim, the program must include better screening and training of the "buddies."

- The County should assign specially trained custody staff to the mental health units. The County should develop a welfare check form for watches, which

should include space for staff members to make observations about the subject's condition.

- The County should eliminate suicide hazards highlighted by our experts (e.g. exposed bars on the lower bunks in observation cells), as well as upper bunks from suicide/special needs housing.

- The County should increase the annual mental health and suicide prevention training from a two-hour curriculum to a minimum of four hours. The County should update and deliver the training at least annually.

- The County should use the Continuous Quality Improvement Program to ensure that staff follow watch policies and that they notify the physician when a prisoner is placed in the observation area.

- The County should enforce a policy for the receiving area that (1) prevents arresting/transporting officers from leaving before they have completed documentation about a drop-off detainee's behavior, (2) requires docket officers to accurately report what they observe about a detainee's behavior or learn about the behavior from oral reports by transporting officers; and 3) requires that security/booking staff provide Naphcare's staff with copies of these reports, flagging those that document health and/or mental health concerns.

- The County should try to give prisoners more time out of their cells, as well as more regular recreation. The County should set schedules for out-of-cell and recreation time, instead of relying so heavily on officer discretion.

- As an initial remedy, the County should consider waiting until after lunch has been served, eaten, and cleaned up, before locking prisoners into their cells.

D. Environmental Safety and Sanitation.

- The County should improve general cleanliness and maintenance in housing units. Initially, the County needs to remove graffiti from the units, fix damaged emergency buzzers, and repair leaking plumbing.

- The County should ensure that a cleaning program includes dayrooms and furniture, as this will also make more space available to medical staff who need an area to conduct patient interviews.

- More long-term, the County should improve staff training on how to maintain sanitary conditions, which can be included as part of a prisoner behavior management program and ongoing, broader policy reviews.

- The County should promptly and continuously replace worn out suicide smocks, blankets, and mattresses. More generally, it needs to keep enough supplies on hand to account for population surges and wear-and-tear.

CONCLUSION

In summary, the County has made substantial progress in improving medical care. And the recent decision to apply for an NIC grant to improve classification policies is a major step towards resolving security issues in the Jail. If the County continues with these improvements, while also implementing the above recommendations about prisoner safety and supervision, medical care, mental health care, and environmental safety/sanitation, we anticipate matter resolution in the near future.

As we advised in the past, a written response outlining a plan and tentative deadlines for implementing our recommendations would likely speed up this process. Such a written plan could help organize your clients' remedial efforts. It would also give DOJ more notice about proposed remedies, so that we could provide additional technical assistance. We also believe this matter could be closed more quickly if we had a schedule for quarterly telephone updates, which would let us provide feedback as the County implements our recommendations. Please advise how the County would like to proceed.

If you have any questions, please feel free to call me at (202) 514-8892.

Sincerely,

Christopher N. Cheng
Attorney
Special Litigation Section